

LETTERS TO THE EDITOR

Retrospective study of male lichen sclerosis and outcome in Leicester: 1995–9 inclusive: experience of a genitourinary medicine clinic

EDITOR,—We have studied retrospectively 76 male cases of lichen sclerosis (LS) (formerly called balanitis xerotica obliterans), that presented over the period 1995–9 inclusive, in Leicester.

These cases were predominantly diagnosed on clinical grounds by experienced clinicians with eight (10.5%) proved by a biopsy.

A clinical diagnosis was made from the presence of combinations of clinical features.

From the literature it can be found that LS is the commonest cause of meatal stenosis in adults and children.¹ Most men present with a phimosis so may require circumcision.¹ Complications include meatal or urethral stricture and some lesions progress to malignancy.¹

The fact that LS of male genitalia can involve the anterior urethra is highlighted by Barbagli *et al.*² In their series of LS cases there was external meatus involvement in 19%, fossa navicularis in 16%, penile urethra in 3%, and notably panurethral disease in 52%.²

Nasca *et al* found that malignant changes were associated with 5.8% of the cases of penile LS in their series of 86 patents from Catania and Rome.³ They emphasise that patients with genital LS are at considerable risk for the development of penile squamous cell carcinoma, as well as verrucous carcinoma and erythroplasia of Queyrat.³ They also suspect that epithelial dysplasia *per se* may be precancerous.³ Reports in general on LS from GUM clinics are rare; notably Bingham reported a solitary malignancy in LS in 1978 from a GUM clinic in a 39 year old man.⁴

Recent studies on LS have shown that susceptibility to the disease may be partly genetically predetermined by having certain human leucocyte antigens—namely, class II loci HLAs, DQ7, or DR11.⁵ Also, Clifton *et al*⁶ have recently postulated that there is evidence for the loss of androgen receptors with disease progression in LS; thus supporting a hormonal pathogenesis of LS. This assertion also provides a rationale for the use of testosterone creams in LS.

In Leicester, we have found that there is a tendency for cases to be referred to dermatologists and/or urologists early, and they are therefore lost to follow up by the GUM clinic. Eighty eight per cent of the men were white, with 9.2% being Asian; 84% were lost to follow up as at the year 2000, with 17% and 18% referred to dermatologists or urologists at any time respectively. Eighty four per cent used 1% hydrocortisone cream at any time; steroids creams stronger than 1% hydrocortisone were used in 21.1% of the cohort and 92.1% of the cohort were uncircumcised. Early referral means that procedures—for example, meatotomy or urethroplasty or therapeutic circumcision, are not recorded often in GUM notes. There was also a tendency for dermatology or urology not to “update” the GUM clinic with time. Despite

this, phimosis was found in 40.8% with meatal stricture in 19.7%, therapeutic circumcision in 15.8%, and malignancy in one case. Anterior urethral involvement was present in only 7.9% in our series, meaning that it may represent a late stage phenomenon. Biopsies were found to be 100% confirmatory of diagnosis of LS—that is, 8/8 biopsies done.

One must conclude that a multidisciplinary approach to LS care should continue to operate, and that long term follow up is mandatory.

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Chaperoning male patients

EDITOR,—Torrance *et al* reported on genitourinary physicians' experience in the use of chaperones in clinics of genitourinary medicine,¹ and Bignell broadened the debate and suggested further study of whether male genital examinations should be more frequently chaperoned.² We have carried out a small prospective questionnaire study of new male patients inquiring both about the sex of the examining doctor and the preference for a chaperone.

In all, 94 patients were questioned by either KB or CM following clinical examination. Eighty six patients were examined by a male doctor, and eight by a female doctor. Two of the male doctor's patients would have preferred a female doctor, but none of the female doctor's patients, although small in number, would have preferred a male. Fifty two patients were chaperoned and one patient subsequently decided he would have preferred not to have been. None of the 42 unchaperoned patients would have preferred a chaperone to be present, and the sex of the chaperone did not appear to be important, although in this small study a female chaperone was present with a female doctor on only two occasions.

Table 1

	Sex of chaperone		No chaperone (%)
	Male (%)	Female (%)	
Sex of doctor			
Male	13 (100%)	32 (97%)*	41 (100%)
Female	5 (100%)	2 (100%)	1 (100%)

*Represents one patient.

The number and percentage of patients who were satisfied to be examined with a chaperone present according to the sex of the doctor and the chaperone, are summarised in table 1.

In conclusion, it appears in this study that our male patients generally feel comfortable with genital examinations by doctors of either sex, and they do not express the desire for a chaperone to be present. We obviously have not addressed the issue of whether or not it may be desirable from the doctor's point of view for a chaperone to be present.³

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Ciprofloxacin 250 mg for treating gonococcal urethritis and cervicitis

EDITOR,—In the recently published UK national guidelines on sexually transmitted infections and closely related conditions¹ ciprofloxacin 500 mg orally as a single dose has been recommended for uncomplicated anogenital infection due to *Neisseria gonorrhoeae* in adults. However, some studies have shown that an oral dose of 250 mg of ciprofloxacin is an effective treatment for uncomplicated gonorrhoea.^{2,3}

In our department, we have been using ciprofloxacin 250 mg as a single oral dose as first line treatment for uncomplicated gonococcal urethritis and cervicitis and 500 mg of oral dose of ciprofloxacin for rectal and pharyngeal infections since 1997. We reviewed case notes of patients with uncomplicated gonococcal infections who attended our department between 1 January 1999 and 31 December 1999. A total of 61 patients with a positive culture were analysed. Of the 61 patients 42 patients with gonococcal urethritis and cervicitis were treated with ciprofloxacin 250 mg as a single oral dose. Eleven patients were treated with 500 mg of ciprofloxacin. Of the 11 patients five had rectal or pharyngeal infections, two were infected with a strain less sensitive to ciprofloxacin, four were initially treated with 250 mg of ciprofloxacin and subsequently given 500 mg of ciprofloxacin when rectal/pharyngeal cultures were found to be positive. Five patients with pregnancy or risk of pregnancy were treated with 3 g amoxycillin with 1 g probenecid and three patients (two pregnant patients with history of allergy to penicillin and one patient infected with a strain resistant to penicillin and less sensitive to ciprofloxacin) were treated with 2 g of intramuscular spectinomycin. In the group treated with 250 mg of ciprofloxacin, 35 (83%) patients, and in the groups treated with 500 mg ciprofloxacin, amoxycillin, and

Table 1 Minimum inhibitory concentration (MIC)

Serial No	Penicillin	Ciprofloxacin	Spectinomycin
1*	>10 µg/ml (resistant)	0.125 µg/ml (less sensitive)	16 µg/ml (sensitive)
2	0.64 µg/ml (less sensitive)	0.125 µg/ml (less sensitive)	16 µg/ml (sensitive)
3*	>10 µg/ml (resistant)	0.125 µg/ml (less sensitive)	16 µg/ml (sensitive)

*Contracted the infection in Thailand.

spectinomycin, all patients attended for at least one repeat smear and culture. In all tested cases repeat smear and cultures were negative. Of seven patients who defaulted for test of cure despite repeated recall letters, five were below the age of 19. The strains isolated in three patients were less sensitive to ciprofloxacin (see table 1). Of the three patients two had infection due to penicillinase producing *Neisseria gonorrhoeae* (PPNG) and they contracted the infection in Thailand. Two of these patients were treated with a single oral dose of 500 mg of ciprofloxacin and one patient was treated with 2 g of intramuscular spectinomycin and subsequently culture became negative.

The proportion of quinolone resistant *Neisseria gonorrhoeae* isolates is rising throughout the world and the levels of resistance in these isolates have risen substantially in recent years.⁴ In Britain, ciprofloxacin resistance is associated with imported cases especially from the Far East⁵ and high level resistance to ciprofloxacin has also been reported.⁶ However, treatment failure remains low especially if the infection is acquired within the United Kingdom.⁵ Moreover, it has been reported that failure rate of ciprofloxacin treatment is lower than the percentage of ciprofloxacin resistant isolates and therefore in vitro resistance to ciprofloxacin may not translate into clinical treatment failure.⁴

A single oral dose of 100 mg ciprofloxacin has been reported to be effective in eradicating uncomplicated urethral gonorrhoea in men.² In our study a single oral dose of 250 mg of ciprofloxacin was found to be effective for treating uncomplicated gonococcal urethritis and cervicitis. However, consideration may be given to a higher dose of ciprofloxacin or other alternatives when the infection may have been acquired in locations where resistant strains are endemic.

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Investigation of the increased incidence of gonorrhoea diagnosed in GUM clinics in England, in 1994-6

EDITOR,—Hughes *et al*¹ recently presented an investigation of the increased incidence of gonorrhoea diagnosed in GUM clinics in England, in 1994-6 within which they have included the data from our clinic.

We reviewed the incidence of gonococcal infection diagnosed in the department of genitourinary medicine, Coventry Healthcare NHS Trust in 1994 and 1996, using the same criteria which had been applied in their study (see table 1).

Similar to Hughes *et al*, we found that the incidence of gonorrhoea had increased remarkably in 1996 compared with 1994 (48 cases in 1994 and 94 in 1996). Of the total number of patients, 49 had other acute STIs at the time of presentation including 37 of them with chlamydial infection; 13 patients were homosexual and four had infection in the oropharyngeal, rectal, or both sites; 39 patients had attended the clinic previously and eight of them suffered from gonococcal infection.

We found a completely different picture with respect to the incidence of penicillin resistance in the gonococcal isolates; while six patients (13.5%) were found to be penicillin resistant in 1994 only three (3.03%) were found to be penicillin resistant in 1996; four homosexual patients were found to be penicillin resistant and two of them had contacts who lived outside Coventry. We have been using penicillin as the first line of treatment for gonorrhoea for the past 20 years or more and the incidence of treatment failure in our area is very low. Accordingly, we believe that the causes of increased incidence of gonococcal infection in the Coventry area are not related to penicillin resistance.

Although most of the patients infected were white, 117 cases (82%), the incidence of gonococcal infection was disproportionately high in black ethnic group, 19 cases (13%); this group however contributed 1.9% of the population in Coventry. Six patients were of Asian origin and interestingly they were second generation Asians and five of them were male, single, of 20-25 age group, and having three or more sexual partners.

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Table 1 Incidence of gonorrhoea in 1994 and 1996

Subjects	1994	1996
Cases	48	94
Male	34	65
Female	14	34
Heterosexuals	43	86
Homosexual	5	8
white	36	81
African/Caribbean	9	10
Asian	3	3
Penicillin resistance	6	3
Other STI	13	34
Chlamydia	10	27

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Perceptions of disease and therapy are factors influencing adherence to antiretroviral therapy

EDITOR,—HIV infection is now considered a chronic condition. Patients will have to learn to live with the disease for their life. Therefore, the management of psychological aspects, besides clinical ones, is becoming increasingly important. In most cases the infection can be controlled by effective but complex treatments. On the other hand, people living with HIV face everyday problems related to the disease, the therapy, and a persisting social stigma which inevitably influences their behaviour. Based on this, the patients' perceptions of disease and therapy may be important in adherence of patients to treatment,¹ which is now an important aspect in HIV care.^{2,3} The study, "Compliance in HIV" has analysed the role of these factors on adherence to therapy.

This is a multicentre observational study focused on evaluating the level of adherence to anti-HIV therapies conducted in Italy. Eligible for the study were HIV+ patients, aged >18 years using combination therapy (bi- and tri-combination therapy) identified in randomly selected days during June 1998 at five outpatient clinics (Milan, Brescia, Florence, Rome, and Naples). Patients were asked to read and sign the informed consent form. They were interviewed by trained psychologists. The questionnaire includes information on general characteristics, clinical conditions, therapy, adherence to therapy, expectation, personal relationship, and perceptions of life, the future, disease, and therapy. In particular, patients were asked to indicate how they perceive HIV disease (among the following adjectives: enslaving, cruel, threatening, invasive, constructive) and the therapy (among the following adjectives: protective, reliable, allied, exigent, enslaving). Each subject could indicate more than one adjective. Less than 5% of eligible subjects refused the interview. Adherence was measured as the number of errors made in the previous week and the past 2 months. Errors made in the previous week were indicated first and then errors made in the previous 2 months in order to help patients to recall less recent events. The kinds of errors investigated included: missing doses of one specific drug, interrupting the entire combination, altering time schedule, wrong association with food, wrong association of drugs, wrong count of pills. Adherence to treatments was defined as follows: high: less than 2 errors; medium: 3-4; low: 5 or more during the 2 months before interview.

In all, 214 HIV infected subjects were enrolled: 63.6% were males and 36.4% females. The age distribution was <24 years 3.8%; 25-34 years 43.4%; 35-44 years 37.4%; 45 years 15.4%. The average time from HIV diagnosis was 6.8 years; 61.2% of respondents reported having HIV related symptoms (currently or in the past). Combination therapies most used were: stavudine, lamivudine, in-

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